Patient-Centered Medical Home Program Appendix

This Patient-Centered Medical Home Program Appendix ("Appendix") is made part of the Agreement ("Participation Agreement") entered into between **HP HealthCare Insurance Company,** contracting on behalf of itself, **HP Affiliates** (collectively referred to as "HP") and the health care professional or entity named in the Participation Agreement ("Medical Group").

HP and Medical Group each agree to be bound by the terms and conditions contained in this Appendix related to the Medical Home Program ("Program"). In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Participation Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix shall be defined as set forth in the Participation Agreement.

SECTION I
Definitions

1.1 "Effective Date" of the Program is May 1, 2009.

1.2 "Medical Home Member(s)" are HP Customer(s) eligible for the Program because their Payer and respective Benefit Plan has elected to participate in the Medical Home Program ("Program") and who are attributed to Medical Group as defined by the attribution methodology described in Exhibit B.

1.3 "Medical Home Roster" is the list of Medical Group locations participating in the Program identified in Exhibit A.

1.4 "Medical Home Services" are comprehensive primary care health care services as opposed to episodic services rendered in a Medical Home model and reimbursed on a non-transaction claim basis. Care is coordinated and integrated across all elements of the health care system and the patient's community, facilitated by the use of registries, information technology and health information exchange.

1.5 "Payment Quarter" is one of the four calendar quarters defined by the start date of January 1, April 1, July 1, or October 1.

January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Payment Quarter 1	Payment Quarter 2*	Payment Quarter 3	Payment Quarter 4

1.6 "Panel Report" is the list of Medical Home Members attributed to Medical Group for this Program per the attribution methodology described in Exhibit B. The Panel Report is run the month preceding the Payment Quarter.

1.7 "Panel Size" is the total number of Medical Home Members attributed to Medical Group as specified in the Panel Report.

1.8 "PMPM" is per-member-per-month.

1.9 "Qualifying Month" is the calendar month that Medical Group has validated and HP has agreed to the validation that that Medical Group has met the requirements for the Program as described in Section 3.1 of this Appendix.

1.10 "HP's Program Team" is the assigned HP support staff and third party staff, that will be working with the Medical Group for implementation and management of the Program**.**

SECTION II
Participating Plans

2.1 Participating Plans. This Appendix applies to the Benefit Plans sponsored, issued or administered by or accessed through HP or HP's Affiliates as listed in Participation Agreement, although only the Benefit Plans that have Payers participating shall be subject to this Appendix. HP may add Benefit Plans subject to this Appendix upon 30 days notice to Medical Group. Benefit Plans excluded from the Program for purposes of this Appendix are: **Administrative Only Service (ASO) Benefit Plans and any Medicare Benefit Plan that does not require the selection of a Primary Care Physician.**

SECTION III
Medical Group Requirements and Responsibilities

3.1 NCQA Recognition Requirements. Medical Group must achieve the NCQA recognition requirements and HP's supplemental capabilities as described in the Table 1 below. HP will designate Medical Group into a respective tier, based on the level of NCQA recognition. This does not preclude Medical Group from attempting to achieve or be designated into a higher tier upon achievement of a higher NCQA designation.

Table 1 HP Medical Home Program Tier

HP Program Tier	NCQA Recognition Requirements
Tier 1	Level 1
Tier 2	Level 2
Tier 3	Level 3

Medical Group is required to obtain the HP Program Tier within the following timelines. Once the Program Tier is attained, the Medical Group will maintain the capabilities inherent in achieving the Tier.

i. Medical Group will achieve Tier 1 of the Program within 6 (six) months after the Effective Date;

ii. Medical Group will achieve Tier 2 of the Program within 18 (eighteen) months of the Effective Date;

iii. Medical Group is encouraged to pursue Tier 3 of the Program during the 24 (twenty four) month pilot period.

For purposes of validating the Qualifying Month, Medical Group must submit written documentation to HP in order to demonstrate that the requirements are met. Such documentation shall include:

i. NCQA documentation in the form of a copy of NCQA receipt of delivery;
ii. Subsection (i) documentation must be followed up by the Medical Group providing formal NCQA recognition documentation;
iii. If the formal NCQA recognition is not provided to HP within 21 days after Medical Group received NQCA recognition, HP may terminate participation in the Program in accordance with Section 5.2 of this Appendix;
iv. HP will distribute earned Care Management Fee PMPM in accordance with Section V of this Appendix.

3.2 Collaboration with HP's Designees. Medical Group will develop a mutually agreed upon process with HP to share information with HP or HP's designee in order to support the efforts of the Program and the Medical Group's effort to achieve NCQA recognition.

3.3 This section intentionally left blank.

3.4 Wellness and Education. The Medical Group agrees to proactively engage the Medical Home Members during the term of the Program with wellness/education tools and health related consumer materials. The Medical Group may solely sponsor education or collaborate with HP for patient wellness education.

3.5 Medical Home Member Satisfaction Survey. The Medical Group agrees to administer a Medical Home Member satisfaction survey to occur during the first quarter of the Program and thereafter on a six (6) month basis until the end of the expiration or termination of the Program. Results of the survey will be shared on an aggregated basis.

3.6 Care Management. In order to support the care management role of the Program, Medical Group will:

i. Review HP's care management recommendations for referral of Medical Home Members to HP's disease management programs;

ii. Review with HP's Program Team Medical Home Member patient satisfaction survey results;

iii. Share lab results and applicable clinical data with HP, in order to attempt to fill care delivery gaps;

iv. Meet with HP on a mutually agreed schedule to review Medical Home Members' care plans, care delivery gaps and potential health risks, and transitions of care. HP and the Medical Group Care Coordinator will establish the frequency and schedule for regular meetings.

3.7 Program Meetings. Medical Group agrees to participate in the following Program meetings:

Meeting Name	Purpose	Frequency
Performance Report Reviews	To review with Medical Group practice lead and business manager(s)/lead physicians Medical Group's performance and to review agree-to Practice Performance Measures.	These meetings occur at least semi-annually.

SECTION IV
HP Responsibilities

4.1 Panel Report. On at least a quarterly basis, HP will provide a Panel Report to Medical Group that includes a listing of all Medical Home Members attributed to Medical Group in accordance with the attribution methodology outlined in Exhibit B. The Panel Report will identify counts for both participating and non-participating ASO's. If the Panel Size has a substantial decrease in Medical Home Members from the prior quarter, HP will provide available information to Medical Group to explain the decrease in Panel Size. For purposes of this Appendix, a substantial decrease in Medical Home Members shall be a loss greater than 15% (fifteen percent) of the Panel Size in the prior quarter.

4.2 Reports and Data Sharing. HP will provide to Medical Group the following reports:

Report	Purpose	Frequency
Panel Report	To identify the current list of Medical Home Members attributed to Medical Group.	At least quarterly
Practice Landscape Analysis	To provide a baseline analysis of Medical Group's patient panel to enable decision making by HP's Program Team and to identify the opportunities of Medical Group including, member demographics, quantitative analysis of inpatient activity, ER utilization, E-prescribing utilization/pharmacy metrics, radiology and specialist referrals by quality designation.	An initial report will be created during the first twelve months of the Program and thereafter produced and distributed on a semi-annual basis
Practice Data Sets	To provide data to Medical Group in order for Medical Group to manage and improve the quality for care for Medical Home Members. This patient specific data includes, but is not limited to: 1. Avoidable/preventable admits and readmits 2. Avoidable / preventable / non-emergent ER visits 3. Referral to HP's participating providers who have achieved both the quality and	Monthly

Report	Purpose	Frequency
	efficiency designations from the HPHealth Premium Designation Program and other HP participating specialists 4. Pharmacy quality and efficiency metric results 5. Radiology quality and efficiency metric results 6. Chronic care management quality metric results	
Care Management Report	To identify at risk or transitional Medical Home Members who require timely care management.	Weekly

4.3 This Section Intentionally Left Blank

4.4 Care Management Resource. HP will provide a care management resource ("HP Care Advocate") and/or care management information process to assist Medical Group with care coordination and care management recommendations based on HP's pharmacy, eligibility, claims data and Medical Home Member Benefit Plan information which can be accessed at the Medical Group's discretion. The HP Care Advocate will work together with Medical Group upon mutually agreed schedule in reviewing clinical information including but not limited to gaps in patient care, inpatient visits, and emergency room admissions to develop care management Medical Home Member care plans.

4.5 Wellness Programs. HP may provide promotional/communication materials to support the Medical Group's wellness education for the Medical Home Members and will assist the Medical Group in the identification of HP wellness programs and other information resources, where applicable.

SECTION V
Payment

5.1 Care Management PMPM. HP will pay a prospective fee to Medical Group on a per- member-per-month basis ("Care Management PMPM") to compensate Medical Group for providing Medical Home Services to Medical Home Members as long as Medical Group achieves and maintains the requirements outlined in Section 3.1 of this Appendix.

The rate of the Care Management PMPM's is based upon Program tiers achieved by Medical Group for the corresponding type of Benefit Plan(s) types as outlined below.

Table 5.1 Program Care Management PMPM for All Benefit Plans

Program Tiers	Care Management Rate
Tier 1	$x.00
Tier 2	$y.00
Tier 3	$z.00

The total reimbursement amount for the Care Management PMPM is determined by multiplying the Care Management Rate by the Panel Size.

5.2 Care Management Payment. Medical Group will begin earning the Care Management PMPM on May 1, 2009.

The Care Management PMPM will be payable to Medical Group upon Medical Group's attestation of its submission of the NCQA application, commitment to evaluate and pursue e-prescribing, and participate in an electronic disease registry.

During the first quarter of the Program, Medical Group will be paid the Care Management PMPM on or about the 15th of the subsequent month following the Qualifying Month. Thereafter, Medical Group will be paid the Care Management PMPM on or around the 15th of a Payment Quarter. If the Care Management PMPM is paid on a quarterly basis, the Care Management PMPM will be paid for an entire Payment Quarter.

During the initial process of NCQA application and before a Tier designation is received, Medical Group will be paid at Tier 1. Upon notification that the Medical Group has initially qualified at a higher tier, a subsequent adjustment to the higher compensation rate for the initial quarter will be made, retroactive to May 1st.

After the initial NCQA recognition, a retrospective reconciliation will occur if the Medical Group achieves a higher level of NCQA recognition during the term of the Program. HP will reconcile the Care Management PMPM back to the first of the month following the date the Medical Group achieved the higher NCQA recognition. The reconciliation payment will be paid during the next Payment Quarter.

5.3 Termination Impact on Care Management PMPM Payments. If the Participation Agreement is terminated by either HP or Medical Group, HP agrees to pay Medical Group the Care Management PMPM up through and including the month of the effective termination date for all Medical Home Members.

SECTION VI
Term and Termination

6.1 Term. This Program shall take effect on the Effective Date and terminate on April 30, 2011 unless terminated early in accordance with Section 6.2. Upon mutual agreement, the Program may renew for renewal terms of one year, unless terminated early in accordance with Section 6.2.

6.2 Termination. This Appendix may be terminated under the following circumstances:

i. by mutual agreement of the parties;

ii. by either party, upon at least 90 days written notice;

iii. by HP effective immediately if Medical Group does not achieve or does not maintain the requirements listed in Section 3.1 of this Appendix;

iv. by either party upon 60 days written notice in the event of a material breach of this Appendix by the other party, except that such a termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover termination may be deferred as further described in Article VIII of the Participation Agreement:

v. Medical Group's participation in the Program will terminate upon termination of Medical Group's Participation Agreement by either party on the same date that the Medical Group's Participation Agreement terminates. However, if either party terminates the Program, then termination of Medical Group's participation in the Program will not result in termination of the Participation Agreement.

HP HealthCare Insurance Company, on behalf of itself and its Affiliates	_____ Name of Medical Group _____ Tax I.D. Number
Signature Name _____ Title _____ Date_____	Signature Name _____ Title _____ Date _____

Exhibit A

Medical Group Program Participating Locations

The following Medical Group locations will be participating in the Program:

(1) Address:_____

(2) Address:_____

(3) Address:_____

(4) Address:_____

(5) Address:_____

Exhibit B

Attribution Methodology

Customers will be considered Medical Group's Medical Home Members based on the following attribution methodology:

1) Where Benefit Plans require a Customer to elect a primary care physician or where a Payer assigns a Customer to a primary care physician ("PCP"), if the Customer selects or a Payer assigns a Medical Group Physician then that Customer will be attributed to that Medical Group as a Medical Home Member.

2) For Benefit Plans that do not require a Customer to elect a PCP or the Payer does not assign a Customer to a PCP, HP will review the Customer's most recent twenty-four (24) months of claims in order to attribute a Customer to the Medical Group

The above methodology utilizes a Customer's most recent twenty-four (24) months' claims history to determine the most recent service date of either a primary care physician visit (as defined in the CPT Codes below) or pharmacy prescription written by a Medical Group Physician in order to attribute a Customer to Medical Group.

For purposes of the attribution methodology, primary care specialties are: internal medicine, family practice and pediatrics.

If the methodology results in two PCPs attributed to one Customer with a most recent service date, the final attribution will be established by:

1) Physician with the maximum count of physician visits or pharmacy prescriptions written per Customer; if these are equal then,
2) Physician with maximum allowed spend, if these are equal then,
3) Physician with the first physician identifier.

Physician visits for primary care specialties include the following CPT codes:

- Office Visit E&M New & Established (CPT codes 99201 - 99205; 99211 - 99215)
- Office Visit Preventive New & Established (CPT codes 99381 - 99387; 99391 - 99397)
- Office Consult (CPT codes 99241 - 99245)

Medical Home Members who have previously been attributed to Medical Group but do not have claim history within the prior 24 months related to a PCP visit or a prescription written by a non-Medical Group Physician, may continue to be attributed to Medical Group until the Medical Home Member receives services from a PCP outside of Medical Group or has a prescription written by a PCP outside of Medical Group.